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ABSTRACT

Limited literature exists describing the melding of philosophies aimed at increasing men's use of mental health counseling services. Members of the mental health counseling profession will benefit from collaborating with other health care professional to conceptualize alternative means to encourage men to use mental health counseling services. This phenomenological-heuristic hybrid study brought four male health care providers together to discuss their experiences and viewpoints on men's avoidance of mental health care counseling services. A focus group discussion produced a series of recurring themes and a possible strategy for interdisciplinary practice. Pairing physical and mental health check-ups that emphasize health and wellness versus pathology will be the interdisciplinary practice highlighted. (Contains 12 references.) (Author)

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Running head: COLLABORATION BETWEEN PHYSICIANS AND COUNSELORS

Physicians And Counselors Collaborate On Men's Avoidance Of Mental Health Counseling Services: A Preliminary Study

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Abstract

Limited literature exists describing the melding of philosophies aimed at increasing men's use of mental health counseling services. Members of the mental health counseling profession will benefit from collaborating with other health care professionals to conceptualize alternative means to encourage men to use mental health counseling services. This phenomenological-heuristic hybrid study brought four (4) male health care providers together to discuss their experiences and viewpoints on men's avoidance of mental health counseling services. A focus group discussion produced a series of recurring themes and a possible strategy for interdisciplinary practice. Pairing physical and mental health check-ups that emphasize health and wellness versus pathology will be the interdisciplinary practice highlighted.

Physicians and Counselors Collaborate on Men's Avoidance of Mental Health Counseling Services: A Preliminary Study

The Problem:

American men die sooner than American women (Anderson & DeTurk, 2002). Attempts to account for this actuarial fact have included hypotheses that: (a) men engage in high risk behaviors more than women, (b) men avoid medical care for physical problems, and (c) men avoid mental health care for psychological problems (Courtenay, 1998). This article focuses on the third hypothesis: that is, men avoid mental health counseling for psychological problems.

Although no empirical data yet exists that quantitatively demonstrates that men use mental health counseling services less than women, it has long been suggested and still believed to be true. Not only do men tend to avoid the use of mental health counseling services, but they also seem to avoid medical health-care professionals while engaging in risky, non-health promoting behaviors (Courtenay, 1998). According to Courtenay (1998) men's cancer death rate has steadily increased over the last 35 years. Men continue to die earlier than women and have higher death rates from the top 10 causes of death, which include: heart disease, cancer, stroke, chronic lung disease, accidents, pneumonia/influenza, diabetes, HIV, suicide, and chronic liver disease (Ventura, Anderson, Martin & Smith, 1997). According to Courtenay (1998) men's health has shown little signs of improvement over the last three decades. Ironically, Courtenay (1998) seems to imply that although most of these diseases, deaths, and injuries are preventable, men and boys across the age, race, and socioeconomic spectrum continue to engage in risky non-health promoting behavior, while avoiding seeking help.

The inattentiveness by men and boys to the avoidable physical and psychological pain, injury, premature disability and death seems tragically wasteful. Preventing this "preventable" harm to men is the focus of this work.

While Courtenay's work (1998) focused specifically on college men's health issues, relevant data and trends for males across the adolescent to adult male spectrum also confirm his results. Key issues from his work have application to this current study. Along with a failure to adopt health-promoting behaviors, Courtenay (1998) identified seven (7) other factors contributing to men's health and mental health risks. Those eight (8) factors are as follows:

- Failure to adopt health promoting behavior
- Risk behavior
- Masculinity
- Concealing vulnerability
- Perceived invulnerability
- Health knowledge
- The health effect(s) of socialization
- The influence of gender and stereotype

The Study

In this qualitative study, the term "counseling" as defined by the American Counseling Association (1995) was used and will be used interchangeably with the phrase, "mental health counseling". Six (6) questions using that definition of counseling provided direction for a focus group discussion comprised of three (3) physicians, and facilitated by a Professor of a Mental Health Counselor Education program. The focus group discussion centered specifically on men's avoidance of mental health counseling services.

The six questions guiding the focus group discussion were:

Question 1. : No actual data exists that empirically shows that men use mental health counseling services less than women; however, there is a suggestion that they do, and unless mandated by a third party, it is suggested that men would avoid the use mental health counseling services. What is your response to this?

Question 2. : If the previous statement (presented in question one) is true, why do you think men avoid using counseling services? What are the barriers causing men to avoid counseling services?

Question 3. : What distinctions (if any) do you think men make between counseling services and mental health counseling services?

Question 4. : Do you think a stigma exist (if so, what is the stigma) for a man who uses counseling services?/mental health counseling services? Is there a distinction in your understanding?

Question 5. : Is mental health counseling/counseling a viable option for men to address their personal, social, spiritual, and emotional concerns? Are there other options?

Question 6. : How can mental health counseling be presented/marketed that could induce men to take advantage of the services provided?

To date, this may be the first study that brings a small group of health care providers together with the expressed purpose of attempting to increase men's participation in mental health counseling; consequently, it requires a methodology that diverges from convention.

A phenomenological/heuristic approach proved vitally important for this research endeavor. In phenomenological studies, the phenomenologist seeks to understand the social phenomenon from the actor's own perspective (Patton, 1990). Hence, male physicians in this study presented their understanding about men's avoidance of mental health counseling, although they see and treat men in their own practices for other health concerns. It is believed that physicians can add another voice to this discussion;

consequently, members of the counseling profession may benefit from having an expanded and possibly divergent perspective presented. Heuristic inquiry, although a form of phenomenological approach, allows the researcher to enter the experience of the phenomenon as a participant as well (Patton, 1990). In heuristic investigations the possibility of a researcher exclaiming, "eureka", or "I discovered" as a result of his participation is an investigative benefit. Consequently, the physicians and the Counselor Education facilitator collaborated to conceptualize and investigate novel ways of understanding men's avoidance of mental health counseling behavior.

Participant Responses

Following is a presentation of excerpted responses to the six questions from the physician participants.

Question 1.: No actual data exists that empirically shows that men use mental health counseling services less than women; however, there is a suggestion that they do, and unless mandated by a third party, it is suggested that men would avoid the use of mental health counseling services. What is your response to this?

"...A lot of that is because of the environment that we're brought up in, the socialization process and expectations that were given to us by our parents" (physician # 1). "...They don't like to feel like they're not in control of the situation and I think going in for counseling is in a sense the assumption that I've lost control, things are not going my way, and I don't know what to do, and I think those are tough admissions for men to make. Even if there isn't data to indicate that this is true, I suspect the data is out there waiting to be counted" (physician #2). "...I see this a lot with patients coming to the hospital often with chest pains or heart attacks, and just getting male patients to sometimes admit that they do have health problems, there's some difficulty with that sometimes, let alone trying to bring in a discussion about mental health, its much harder for men to admit they have a mental health problem than sometimes physical problems, I see that a lot in my practice" (physician #3). "...I think it is easier for men to admit to a physical problem because it can be in some sense objectified as a mechanical problem. It's no reflection on my masculinity or my competence to say that I have bad knees or

perhaps that I have a bad heart, it's a mechanical problem, not a moral weakness or psychological weakness or an incompetence…but a mental health problem goes deeper, it's a kind of an admission about some flaw in your identity. I think that is very hard for men to admit" (physician #1).

Question 2. : If the previous statement (presented in question one) is true, why do you think men avoid using counseling services? What are the barriers causing men to avoid counseling services?

"…I think a lot of it's the way men are brought up in our society, it's the way they're suppose to be the stronger sex, in charge, making the decisions and admitting that there's a mental problem, its not as easy as admitting that they have a physical problem" (physician #1). "…I think that not only do we avoid it because of our own self-image that we're trying to protect, but we also have concern about what other people might say about us…we as men take shots at each other like, 'Can't put up with it huh?'" (physician # 2). "…Yeah, men don't talk about how we're feeling, you talk about superficial stuff, no opportunities to opens up emotions" (physician #3). "…Women are more intimate with their friends than men are intimate with their friends and all of those are part of I think the difference between autonomy and connection. Men are socialized towards separateness and autonomy and women are much more socialized towards making connection with others. So when it comes down to when there are problems, men are stuck in their separate mode whereas women being able to make connections often reach out readily and seek help" (physician #2). "…We all grew up with John Wayne and the *Sands of Iwo Jima* and you saw the Marines going out there and those that showed a little bit of fear and inability to cope were chastised and brow beaten until they got the macho level up again, so we're all subject to that" (physician # 1). "…We've been talking about male psychology, but I can think of another barrier besides male psychology; male ignorance. I think there's some sort of wonderment like, 'What kind of private invasions of privacy occur in counseling?' …lack of knowledge is one problem" (physician #2). "…Maybe another is that they would be more apt to see a female counselor and I'm not sure males who are having problems might consider counseling then. The idea that counseling might be a women's profession, that touchy feely talking goes on. It may seem like a more feminine approach. Even though I'm throwing these stereotypes around,

I think a lot of men believe it to be the case" (physician #2). "...Actually, we've stereotyped a lot of the work force not just psychology" (physician #1).

Question 3. : What distinctions (if any) do you think men make between counseling services and mental health counseling services?

"...I think mental health counseling would be more related to a specific diagnosis like depression and counseling is just counseling" (physician #3). "...Men may think of marriage counseling, career counseling, or financial counseling" (physician #1). "...In those areas though men are still in charge and the perception I think that would be when you come to mental health counseling, somehow you lose control, that you are now there number one: not willing to admit that you have a problem, number two: going to a place where a male doesn't belong, and number three: going to have to relinquish control about a problem that you really don't have...A sense of powerless and presenting yourself in a powerless way to a mental health counselor is a condition I definitely think men wish to avoid" (physician # 2).

Question 4. : Do you think a stigma exist (if so, what is the stigma) for a man who uses counseling services?/mental health counseling services? Is there a distinction in your understanding?

"...In actuality, its probably more an internal stigma rather than an external one" (physician #2). "...I think there's a change in self image that if I go to counseling its an admission that I'm not strong, I need help, I'm not in control and there's a fear of crossing that line of making that stigmatizing judgment about yourself, its self-image" (physician #1). "...Do you think there's a fear of a loss of being able to achieve because a man went to counseling? That the pilot can't fly and lead the squadron, the man in charge of the multi-million dollar corporation is removed because they went to counseling and they're removed because they're thought to be incompetent?...If I'm a CEO, I'm not sure I'm going to want my competitive drive compromised by becoming more empathic and emotionally aware perhaps. There might be that fear for some men that going to counseling makes you become more sensitive and somehow you will compromise your competitive edge, or demonstrate that I have a defect that up till now I've been able to hide" (physician #2).

Question 5. : Is mental health counseling/counseling a viable option for men to address their personal, social, spiritual, and emotional concerns? Are there other options?

"...Friendships might be an option, but I think we're talking about intimacy. Intimate friendships are where self disclosure is voiced" (physician #2). "...I think the clergy can help for some mental health counseling, sometimes I believe it is more appropriate to discuss some things with reverends, ministers, and priests" (physician #1). "... I think in some ethnic groups, talking to a stranger about personal difficulties is proscribed behavior" (physician #2).

Question 6. : How can mental health counseling be presented/marketed that could induce men to take advantages of the service provided?

"...If everybody would go to mental health counseling, it would be an accepted norm, but if you are the only one, you stand out...everyone goes to their physician for a semiannual check-up, everyone goes to their dentist for a semiannual cleaning, everyone could go to their mental health counselor on a semiannual basis just to see how things are going...perhaps it can be marketed" (physician #2). "...Coupling counseling with some other medical examination might present opportunities. If they come in for some acute medical problem like a heart attack, lumping counseling with that might help because, there is an increased risk of depression after a heart attack" (physician #3). "...One out of 4 people with depression actually seek medical help for depression, so if there was a way to make seeking medical help for depression more common those people might discover in the course of treatment that counseling would be a helpful part of treatment for depression...so maybe more knowledge that many of these problems with depression, anxiety, and stress are difficult to deal with on your own, and a counselor can help educate people about getting help" (physician #2). "...Yes getting men to do yearly health maintenance would help, I think we are a long way away from that though" (physician #1). "...We have a long way to go just educating physicians about picking up on disorders and identifying which people would benefit from counseling that we can't provide in our shortened clinical visits" (physician #3). "...Coupling it, placing it along

side other semiannual check-ups that some men normally do seems that it could make it more comfortable for some" (physician #2).

Discussion

Of the eight factors presented by Courtenay (1998), six (6) were specifically cited by the physicians in this study as barriers preventing men from using mental health counseling services. Those six (6) barriers included:

- masculinity
- concealing vulnerability
- perceived invulnerability
- health knowledge
- the health effect(s) of socialization
- the influence of gender and stereotype

Although not presented in any sequential order, the physicians' responses to the questions related to men's avoidance of mental health counseling services were congruent with Courtenay's (1998) factors contributing to men's health and mental health risks. The initial paradigm in which the physicians and Courtenay (1998) discussed the male perspective on barriers to mental health help-seeking and health-risk behavior was negative, deficit, and pathological in orientation; however, the physicians posed a positive perspective that warrants consideration. Of particular importance for this study is the belief by these physicians that pairing an annual or semi-annual physical examination with a mental health status examination is a logical and useful alternative.

The pairing of a physical examination and mental health status check-up has advantageous implications for physician, counselor, and the male patient/client. In the counselor, the physician has a colleague from another discipline who can specifically address the non-medical psychological and adjustment concerns of the patient using a

series of diverse therapeutic approaches, one of which could be a solution-oriented approach. One of the foundations of a solution-focused approach is that the male patient/client knows that a solution to his problem exists and that he is able to construct a solution applicable to his problem with assistance from the counselor (Walter & Peller, 1992). The counselor benefits from this pairing because he/she can accurately propose some initial intervention that matches the male patient/client's non-medical, adjustment or psychological concern. He/she has the support of and information from the physician, thus ensuring a smoother delivery of services. With collegial collaboration and limited interference a broader more comprehensive treatment regimen will be incorporated. As a result, a strong preventive or anti-deteriorative component exists in the collaboration between physician and counselor.

The male patient/client benefits most. Although related specifically to knowledge of early detection of colorectal and other cancers, research tends to support a belief that men have less knowledge about health matters than women (Polednak, 1990; Bostick, Sprafka, Virnig, & Potter, 1993). Men can thus benefit from a physician who not only treats the medical problem surgically or pharmacologically, but also recognizes the potential psychological and adjustment concerns that may ensue post-medical treatment. The physician can educate the male patient/client to the mind and body connection, thus laying the groundwork for a fruitful association with the counselor. The male patient/client can begin to conceptualize the counseling process as a normative, integrated, and useful approach to health. If, indeed, the male patient/client has concerns related to stigmatization, both physician and counselor can join forces in soliciting the patient's help to identify solutions that are effective, parsimonious, and de-stigmatizing.

The male patient/client is now the recipient of coordinated, collaborative treatment with a smooth seamless transition from physicians providing physical medical care, and the counselor providing emotional and adjustment care. One last aspect of this comprehensive treatment plan bears introduction.

The concept of psychological medicine (Kroenke, 2002) suggests that attention paid to the psychological aspects of medical assessment and treatment can improve medical care. Physicians can accurately distinguish between somatisation and a true medical disorder, thus maximizing their time with patients. Counselors can assist with non-medical interventions that are clinically proven, and the men benefit by receiving and participating in a more unified wholistic intervention. These health care providers joining forces and bringing their various specialties to bear could prove immensely beneficial for the male patient/client.

Physicians have suggested the advantages for all parties considered. If, as according to Courtenay, (1998) men continue to engage in high-risk, non-health promoting behaviors, some will require one-time, emergency, or ongoing medical attention, thus presenting an opportunity to incorporate a mental health status exam with a medical visit. It is during these medical visits that a physician, physician assistant, or counselor-in-residence can provide the mental status assessment.

It has long been suggested that high numbers of medical patients upon presenting medical concerns to their physicians have co-existing mood and substance disorders (Ormel, Von Korff, Ustun, Pini, Korten, & Oldehinkel, (1994). As a result, when the male patient presents for any medical concern, a mental status exam is suggested and warranted. Kroenke (2002) suggested that many purely medical problems can actually

increase the likelihood of an onset of mood disorders. For example, a male client (regardless of age, race, or socioeconomic status) faced with the eventual amputation of a limb would likely experience an onset of bouts of depression or simply develop a depressive mood. An accompanying mental status assessment presented before, during, or after the amputation procedure could mitigate the complexity of the spectrum of loss. In addition, depression tends to accompany cardiovascular and neurological disorders as well as various forms of cancer, all of which men continue to experience at high incidence rates (Kroenke, 2002).

It can be suggested that the genesis of promoting mental health within a medical problem scenario could be beneficial for the male medical patient. The pairing of a mental health status assessment with a medical examination can provide an opportunity for the development of alternative viewpoints about the mental health assessment. Counselors and physicians have a unique opportunity to re-shape the mental health/physical health paradigm. In association with a mental health counseling professional, the physician can present the psychological distress as a consequence rather than a cause of the physical symptom(s) (Kroenke, 2002). Here, the combined efforts of two health care professionals can delineate a change in conceptualizing this dilemma. For example, an adolescent male who was recently diagnosed with a form of bone cancer could benefit from an explanation by a physician that a low red blood cell count causes the body to lose strength, require more rest, and cause one's mood to become lethargic. If the adolescent patient understands the mind/body connection, he may be more receptive to mental health counseling which could be provided to address his situation. Furthermore, if physicians were to clearly delineate the mind-body interconnection the

male patient would be more likely to understand the mental/physical interplay with their own case and therefore they might be participatory in their own health care and promotion.

Physicians and counselors who pair physical examinations with mental health assessments can promote a cost-effective, least-restrictive, and health promotion paradigm.

It has long been suggested that patient/clients who are informed and participatory to the extent possible tend to have satisfactory clinical results (Roter & Hall, 1997). When considering the most economical yet effective and beneficent manner of service delivery, a combination of medication/pharmacological and non-medical interventions have shown promise (Mechanic, 1999). Members of the mental health counseling profession have innumerable numbers of non-medical interventions which when coupled with the physician's intervention(s), provide a more comprehensive, economical, and least restrictive environment. Further, males might prefer to have physical concerns labeled as "medical" whether medical intervention has been prescribed or not. Equally, some men may desire that their mental health concerns be labeled "medical" without pharmacological intervention.

Pairing a one-time emergency visit and/or the semi-annual, or annual, physical examination with a mental health status assessment has logical merit. Physicians can be supported by members of the mental health counseling profession to provide a more comprehensive, cost-effective, and least-restrictive service and males can receive care that is truly characterized as wholistic.

Interdisciplinary collaboration between medical health professionals and mental health counselors on the topic of men's avoidance of mental health counseling warrants further consideration. It is believed that collaboration on this topic could be mutually beneficial for all parties concerned. Because male health-care professionals from other disciplines see men in their practices, it is believed that they can assist in informing mental health counselors how to increase male participation in the counseling process. Furthermore, conceptualizing novel ways of decreasing the barriers that inhibit men's physical and mental health-care awareness and action cannot be effectively conceptualized in a uni-disciplinary manner. In addition, medical professional's views of mental health practice could be influenced in positive directions. Further research might include, the feasibility of having mental health counselors on sight at physicians' offices and at physicians' rounds to provide immediate mental health information and support for medically disparaging news. Counselors can use survey research to ascertain at what point/time in the medical evaluation process mental health counseling would be most advantageous to the male client and professionally supportive to the physician. Finally, more information on what types of counseling approaches would be congruent with men during a time when many may feel frail, injured, and less masculine.

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